JUPITER FAMILY MEDICINE, P.C.
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name_____________________________________ Birthdate________________

Medical Information From:
Office____________________________
Name____________________________
Address__________________________
City, State, Zip____________________

Physician/person/company to receive records:
Name: Jupiter Family Medicine PC
Address 6290 Jupiter Avenue, Suite A
City, State, Zip Belmont, MI 49306
Phone (616) 301-2500

Medical Information to be sent:

_____Entire Medical Record, INCLUDING information related to the treatment for substance abuse or dependency; Psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

____Entire Medical Records, EXCLUDING information related to the treatment for:
Substance abuse or dependency
Psychiatric or mental health treatment
Information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

____Record of care from ________ to ________ INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

____Record of care from _________ to ________ EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

____If deemed necessary by Doctor ______________, I authorize this information to be sent via FAX transmission. HIV, AIDS, and Mental Health records may not be FAXED unless it is an emergency.

I RECOGNIZE THAT UNDER the Health Insurance Portability and Accountability Act of 1966 (HIPAA), I may limit the scope of information that I authorize to be disclosed. It is my expressed wish that all medical records of whatever kind as described above, be released, subject only to the limitations, if any, noted hereafter:__________
____

This applies to all information in my medical record protected under the regulations in 42 Code of Federal Regulations, Part 2.

I authorize medical information to be released as indicated above. I understand this release is effective until __________, but that I may revoke my consent at any time by providing written consent to the above named party.

I FURTHER UNDERSTAND that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and thereafter no longer subject to protection under HIPAA.

Please include these family members:

______________________________	________________
Patient Name	Date of Birth
Patient Name	Date of Birth
Patient Name	Date of Birth

______________________________ ________________
Signature **Date**